

**LINCOLN MEDICAL CENTER AUXILIARY  
P.O. BOX 7744, RUIDOSO, NM 88355**

**TO: Scholarship Applicants**

Attached for your use is the application form to be filled out and return by April 1. Please read carefully and check off as you complete the requirements to be sure you have complied with all.

The following is a list of requirements that apply for this Scholarship Program:

1. I must have lived in Lincoln County for one year or worked at LCMC for one year, must be pursuing further education in the healthcare field, have specified the field on the application, and will meet with the scholarship committee, if requested.
2. If employed, I must have a letter of recommendation from my employer or supervisor.
3. If a high school student, I must have a letter of recommendation from a counselor, teacher, clinical supervisor, or LCMC department head.

I must submit a recent transcript copy of my grades, high school or college, with the application, as well as SAT or ACT scores (if available).

4. I must submit a letter with the application stating my goals and career objectives, some information about myself, and why I would like this scholarship. Included in this letter, I have named other scholarship that I have been awarded/amounts or I have applied to/amounts.
5. I will keep in contact with the LCMC Auxiliary. I must submit proof of enrollment each semester at the beginning of the semester, and grades for those classes at the end of each semester . I must maintain 2.5 average in college/university.
6. I must reapply for this scholarship each school year. The deadline is **ALWAYS APRIL 1**. I understand that the application must submitted to the Auxiliary Scholarship Chairman at LCMC by April 1. of each year. This deadline is non-negotiable.
7. You may request and fill out the application in a PDF form email **bpcov11@gmail.com**

I have read and will comply with the requirements stated. My completed application is attached.

Signed

Date

Attachment/Application

For AUXILIARY USE ONLY:

Received by

Date

**LINCOLN COUNTY MEDICAL CENTER AUXILIARY  
P.O. BOX 7744, RUIDOSO, NM 88355**

**APPLICATION FOR HOSPITAL AUXILIARY SCHOLARSHIP**

Student Name	Email	Phone Number
Address	City	State Zip
Name Of High School	Year Graduated	

WILL YOU ALLOW US TO USE YOUR PHOTO FOR MARKETING ?      YES      NO

WHERE ARE YOU NOW STUDYING OR PLANNING TO STUDY FOR A DEGREE IN HEALTHCARE?			
Name of School		Address	
Name of Study	GPA	Program length	Yrs. Compl

Parent:    Guardian:    Spouse:    (Check One)

Name	Address	Phone Number
Occupation	City, State, Zip	Number of Dependents

STATE WHY YOU NEED FINANCIAL ASSISTANCE:

DO YOU HAVE OTHER FINANCIAL ASSISTANCE? IF YES, STATE FROM WHOM AND HOW MUCH:

WHAT HEALTHCARE FIELD ARE YOU PLANNING TO PURSUE?

GIVE THREE CHARACTER REFERENCES:

Name	Address	Phone
Occupation	City, State, Zip	Phone
Name	Address	Phone
Occupation	City, State, Zip	Phone
Name	Address	Phone
Occupation	City, State, Zip	Phone

LIST YOUR EXPENSES RELATED TO SCHOOL BY SEMESTER: Tuition:    Books:    Other, Please Specify    Total:

NOTE: FAILURE TO COMPLETE ANY OF THE

ITEMS WILL RESULT IN REJECTION OF YOUR APPLICATION

Signature:

LCMC  
AUXILIARY  
SCHOLARSHIPS

FORMS NOW AVAILABLE

DEADLINE FOR APPLICATION IS

APRIL 1, 2016

APPLICATIONS AND INFORMATION AVAILABLE AT:

LCMC-HUMAN RESOURCE OFFICE

(Outside of Joan Pelkey's office in brochure holders

Gifts N' Gab (in scholarship envelope)

PATTY COVINGTON

AUXILIARY SCHOLARSHIP CHAIRPERSON

671-4301

JOAN PELKEY

AUXILIARY VOLUNTEER COORDINATOR

630-4250

APPLICANTS MUST BE ENTERING OR FURTHERING  
THEIR EDUCATION IN THE MEDICAL FIELD

NO APPLICATIONS ACCEPTED AFTER APRIL 1, 2016